TITLE 10: CALIFORNIA CODE OF REGULATIONS
CHAPTER 5.5 MAJOR RISK MEDICAL INSURANCE PROGRAM

Article 1. Definitions

2698.100. Definitions

For the purposes of this part:

(a) "Appellant" means an applicant, subscriber, enrolled dependent, or dependent subscriber who has filed an appeal with the program.

(b) "Applicant" means an individual who has filed an application for major risk medical coverage with the program.

(c) "Authorized Representative" means any person or entity who has been designated, in writing, by the appellant to act on his/her behalf or individuals who have appropriate power of attorney or legal conservatorship.

(d) "Board" means the Managed Risk Medical Insurance Board.

(e) “Certificate of Program Completion” means a certificate issued by the Program to persons leaving the Program after 36 consecutive months of coverage.

(f) "Coverage" means the payment by the program or other health plan or insurer for medically necessary services provided by institutional and professional providers.

(g) “Creditable coverage” means:

(1) Any individual or group policy, contract or program, that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, disability income, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers’ compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.

(3) The Medicaid program pursuant to Title XIX of the Social Security Act.

(4) Any other publicly sponsored program, provided in this state or elsewhere of medical, hospital and surgical care.

(5) 10 U.S.C.A. Chapter 55 (commencing with Section 1071) Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

(6) A medical care program of the Indian Health Service or of a tribal organization.

(7) A state health benefits risk pool.

(8) A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901)(FEHBP).

(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(l) of the Public Health Service Act, as amended by Public Law 104-191.

(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. 2504(e)).

(h) "Day" means calendar day unless specified otherwise.

(i) "Dependent" means:

(1) The spouse of a subscriber or applicant at the time of application.

(2) An unmarried child under the age of 23 at the time of application, who is an adopted child or stepchild pursuant to subsection (C) below, or a natural child who:

(A) lives with the subscriber or applicant; or

(B) is economically dependent upon the subscriber or the applicant.

(C) 1. A child shall be considered to be adopted from the date on which the adoptive child's birth parents or other appropriate legal authority signs a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or a relinquishment form, granting the subscriber or applicant, or the spouse of a subscriber or applicant, the right to control health care for the adoptive child or, absent this written document, on the date there exists evidence of the right of the subscriber or

applicant, or the spouse of a subscriber or applicant, to control the health care of the child placed for adoption.

2. A child shall be considered a stepchild upon the subscriber's or applicant's marriage to the natural or adopted stepchild's parent.

(3) An unmarried child over the age of 23 at the time of application, who is an adopted child or stepchild pursuant to (2)(C) of this section, or a natural child who at the time of attaining age 23 was incapable of self-support because of physical or mental disability which has existed continuously from a date prior to attainment of age 23.

(j) "Dependent Subscriber" means an enrolled dependent that has maintained eligibility pursuant to section 2698.205.

(k) "Disenroll" means termination from coverage by the program.

(l) "Eligible" means the applicant is qualified to be enrolled along with dependents in a participating health plan.

(m) "Enroll" means to accept an individual as a subscriber or as a dependent by notifying a participating health plan to accept the applicant and dependents, if any, for coverage.

(n) "Executive Director" means the Executive Director for the Board.

(o) "Fee-for-service plan" means either of the following:

(1) Service benefit plans under which retrospective payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services rendered to subscribers.

(2) Indemnity benefit plans under which a carrier agrees to pay retrospectively certain sums of money, not in excess of actual expenses incurred, for health services.

(p) "Health maintenance organization" means either of the following:

(1) Comprehensive group-practice prepayment plans which offer benefits, in whole or in substantial part, on a prepaid basis, with professional services thereunder provided by physicians or other providers of health services practicing as a group in a common center or centers. This group shall include physicians representing at least three major medical specialties who receive all or a substantial part of their professional income from the prepaid funds.

(2) Individual practice prepayment plans or network model prepayment plans which offer health services in whole or in part on a prepaid basis, with professional services thereunder provided by individual physicians or groups of physicians or other providers of health services who agree to accept the payments provided by the plans as full payment for covered services rendered by them.

(q) "Health plan" means a private insurer holding a valid outstanding certificate of authority from the Insurance Commissioner, a nonprofit hospital service plan qualifying under Chapter 11A (commencing with section 11491) of part 2 of division 2 of the Insurance Code, a nonprofit membership corporation lawfully operating under the Nonprofit Corporation Law (division 2 (commencing with section 5000) of the Corporations Code), or a health care service plan as defined under subdivision (f) of section 1345 of the Health and Safety Code, which is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal health care services under insurance policies or contracts, medical and hospital service agreements, or membership contracts, in consideration of premiums or other periodic charges payable to it.

(r) "Medicare" means the Health Insurance For The Aged provided under title XVIII of the Social Security Act; "Part A" means Hospital Insurance as defined in title XVIII of the Social Security Act; and "Part B" means Medical Insurance as defined in title XVIII of the Social Security Act.

(s) "Participating health plan" means a health plan which has a contract with the program to administer major risk medical coverage for program subscribers. Participating health plans are categorized as either fee-for-service plans or health maintenance organizations as defined in Section 2698.100 (p) or (q) respectively.

(t) “Pilot Program” means the program established by Health and Safety Code section 1373.62 and Insurance Code section 10127.15.

(u) “Pilot Program health plan” means any health care service plan or health insurer who has enrolled a program graduate into the Pilot Program and a Pilot Program standard benefit plan.

(v) “Pilot Program standard benefit plan” means a benefit package that meets the criteria of Health and Safety Code section 1373.62(c) or Insurance Code section 10127.15 (c).

(w) "Pre-existing condition" means any condition for which medical advice, diagnosis, care, or treatment was recommended or received during a six month period immediately preceding the effective date of coverage.

(x) "Pre-existing condition exclusion period" means that period of time for which there is no coverage for a pre-existing condition.

(y) "Post-enrollment waiting period" means that period of time between the date of enrollment and the date coverage begins.

(z) "Program" means the California Major Risk Medical Insurance Program.

(aa) “Program Graduate” means:

(1) A subscriber in the Program who has completed 36 consecutive months of coverage and has been issued a Certificate of Program Completion by the Program; or

(2) A dependent subscriber who has completed a total of 36 consecutive months of coverage in the program, and has been issued a Certificate of Program Completion by the Program.

(bb) “Program Graduate dependent” means an enrolled dependent who has completed 36 consecutive months of coverage and has been issued a Certificate of Program Completion by the Program at the same time as the subscriber.

(cc) “Resident of the State of California” means a person who is present in California with intent to remain present except when absent for transitory or temporary purposes. However, a person who is absent from the state for a consecutive period greater than 210 days shall not be considered a resident.

(dd) “Standard average individual rate” means that rate a participating health plan estimates it would charge the general public for individual, non-group coverage for the benefits described in the program contract with the participating health plan.

(ee) “Standard monthly administrative fee” means the weighted monthly average per person administrative fee paid by the Pilot Program to participating Pilot Program health plans and calculated in accordance with section 2698.602(d).

(ff) "Subscriber" means an individual who is eligible for and receives major risk medical coverage through the program. "Subscriber" does not include an individual receiving major risk medical coverage through the program as an enrolled dependent of a subscriber. An individual who is enrolled but not yet receiving coverage due to a post-enrollment waiting period is considered a subscriber.

(gg) "Subscriber contribution" means the amount paid by a subscriber or a dependent subscriber on a periodic basis to the program for coverage for a subscriber and/or enrolled dependents, if any, or for a dependent subscriber.

(hh) "Unique Identification Number (UIN)" means a number assigned by the Program to each Program Graduate's Certificate of Program Completion to be used in the

Pilot Program to track each Program Graduate for payment and reporting purposes.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code; ASSEM. Bill No. 1401 (stats. 2002, ch. 794, Sec. 21). Reference: Sections 10900, 10127.15, 12705, 12711, 12712, 12725, 12726 and 12730, Insurance Code; and Section 1373.62, Health and Safety Code.

2698.102. Terms

For the purposes of this part:

(a) "Tenses and Number." The present tense includes the past and future, and the future the present; the singular includes the plural and the plural the singular.

(b) "Time." Whenever in this chapter a time is stated in which an act is to be done, the time is computed by excluding the first day and including the last day. If the last day is a holiday it is also excluded.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Sections 12711 and 12712, Insurance Code.

Article 2. Eligibility, Application, and Enrollment

2698.200. Basis of Eligibility.

(a) All eligibility requirements contained herein shall be applied without regard to sex, race, creed, color, sexual orientation, health status, national origin, occupation, or occupational history of the individual applying for the program.

(b) To be eligible for the program, an applicant shall meet the requirements of either (1) or (2):

(1) Meet all of the following requirements:

(A) Be a resident of the State of California; and

(B) Not be eligible for Part A and Part B of Medicare, except those applicants on Medicare solely because of end-stage renal disease; and

(C) Not be eligible to purchase any health insurance for continuation of benefits under the provisions of Health and Safety Code section 1366.20 et. seq., or under the provisions of Insurance Code section 10128.50 et. seq. or have exhausted any health insurance for continuation of benefits under the provisions of 29 US Code 1161 et. seq.; and

(D) Be unable to secure adequate private coverage. An individual shall be deemed unable to secure adequate private health coverage if the individual within the previous 12 months:

1. Has been denied individual coverage; or

2. Has been involuntarily terminated from health insurance coverage for reasons other than nonpayment of premium or fraud; or

3. Has been offered an individual, not a group, health insurance premium rate in excess of the subscriber rate for the individual's first choice participating health plan.

(2) Be a dependent of an individual meeting the requirements of (b)(1) of this section.

(c) To remain eligible a subscriber, enrolled dependent or dependent subscriber shall:

(1) Remain a resident of the State of California; and

(2) Not become eligible for Part A and Part B of Medicare, except those applicants who become eligible for Medicare solely because of end-stage renal disease; and

(3) Not exceed a total of 36 consecutive months of enrollment from his/her respective start of coverage date in the program as required by section 2698.204(a)(7); and

(4) Make subscriber contribution payments as required by section 2698.403.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Sections 12711, 12725, and 12733, Insurance Code.

2698.201. Application

(a) The Board shall establish an application review process which assures timely action on applications. The program shall complete the application review process within 30 days of receipt of the application and payment of the initial subscriber contribution.

(b) To apply for the program an individual shall submit:

(1) all information, documentation, and declarations necessary to determine program eligibility as set forth in subsection (d) of this section, and

(2) a check or money order for an amount equal to the initial subscriber contribution for the individual's first choice participating health plan.

(c) A complete application is one that meets the requirements of (b)(1) and (b)(2) of this section. All applications shall be reviewed for completeness upon receipt by the program.

(1) If the application is complete, it will be reviewed for an eligibility determination.

(2) An incomplete application shall be returned to the individual and shall not be processed.

(d) (1) The applicant shall use the application form entitled California Major Risk Medical Insurance Program Enrollment Application (December, 2003).

(2) The applicant shall provide the following information:

(A) The applicant’s full name.

(B) The applicant's current home address including house or unit number, street, city, county, state, and zip code.

(C) The applicant's date of birth.

(D) The applicant's sex.

(E) The applicant's marital status.

(F) The applicant's home and/or business telephone number.

(G) If dependents are to be included in the coverage, the full names, dates of birth, sex, and relationship of the dependents to be covered.

(H) The name and address to which the bills for the subscriber contribution are to be sent, if different from the applicant's.

(I) Proof of rejection within 12 months of the date of application for health insurance coverage for reasons other than fraud or nonpayment of premium. The proof shall include a letter or other formal written communication from a health plan, documenting one or more of the following:

1. Having been denied health insurance coverage as an individual.

2. Having been involuntarily terminated from health insurance coverage.

3. Having been offered an individual, not a group, health insurance premium rate in excess of the subscriber rate for the individual's first choice participating health plan.

(J) An initialed declaration that the applicant is not eligible for Part A and Part B of Medicare, in accordance with subsection 2698.200(b)(1)(B).

(K) An initialed declaration that the applicant is a resident of the State of California.

(L) An initialed declaration that the applicant will abide by the rules of participation, utilization review process, and dispute resolution process of any participating health plan in which the applicant is enrolled.

(M) An initialed declaration that the applicant is not, to the applicant's knowledge, being excluded from a group for the purpose of being made eligible for the program.

(N) An initialed declaration that the applicant has reviewed the benefits offered by the participating health plans and the subscriber contribution rates.

(O) An initialed declaration that the applicant understands and will follow the rules and regulations of the program.

(P) Name and address of the applicant's primary employer, if employed.

(Q) The applicant's occupation, if employed.

(R) An initialed declaration that the applicant is not currently eligible to purchase any health insurance for continuation of benefits under the provisions of Health and Safety Code section 1366.20 et. seq., or under the provisions of Insurance Code section 10128.50 et. seq. or has exhausted any health insurance for continuation of benefits under the provisions of 29 US Code 1161 et. seq.

(S) An initialed declaration that the applicant has not been terminated from a standard benefit plan available under the provisions of Health and Safety Code section 1373.62 or Insurance code section 10127.15 within the last 12 months due to non-payment of premiums or as a result of the applicant's request to voluntarily disenroll or as a result of fraud.

(T) An indication of the applicant's selected participating health plan.

(U) If an applicant is not currently eligible for the program, but anticipates becoming eligible, the applicant shall explain and document the reason or reasons, and provide the date on which eligibility will occur.

(V) The applicant or the applicant's parent, conservator, or guardian shall sign and date the application stating that the information given is true and correct.

(3) The following information is requested but not mandatory, and will be used for identification and administrative purposes:

(A) The applicant's ethnicity.

(B) The applicant's social security number.

(C) The dependent's social security number, if dependents are to be included in the coverage.

(e) In order for the program to determine that a pre-existing condition exclusion or a post-enrollment waiting period should be waived, or partially waived, each individual applying for coverage must provide one of the following:

(1) Documentation that the individual had prior creditable coverage, or

(2) Documentation that the individual has been covered by a similar plan sponsored by another state before becoming a resident of the State of California.

(f) Applications may be submitted at any time. An applicant shall not be enrolled nor shall the applicant be placed on a waiting list until the applicant has fulfilled all of the requirements for eligibility. Once the requirements for eligibility are fulfilled, applicants shall be enrolled or placed on a waiting list in order of the date of receipt of the completed application.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Sections 12711, 12725 and 12728, Insurance Code.

2698.202. Determination of Eligibility

(a) Upon receipt of a complete application the program shall determine an applicant's eligibility based upon the criteria specified in section 2698.200.

(b) (1) Applicants determined ineligible shall be notified in writing by the program, except as in (2) below. The notice shall include the reason for the determination of ineligibility and an explanation of the appeal process. The applicant's initial subscriber contribution shall be refunded.

(2) If an applicant is determined to be currently ineligible, but the applicant has documented pursuant to section 2698.201(d)(2)(U) that he/she will become eligible, the applicant shall be notified that the application will be held until the eligibility date specified, and on that date the applicant will be determined eligible. The applicant's initial subscriber contribution shall not be refunded, unless the applicant's eligibility date is more than 60 days from the date of the notification.

(c) Applicants and any dependents determined eligible shall be either enrolled or placed on a waiting list and shall be notified of their status.

(d) Eligible applicants and any dependents shall be enrolled in accordance with section 2698.203, unless one of the following circumstances exist:

(1) There are no participating health plans offered in the applicant's county of residence.

(2) A program funding shortfall has been projected.

(e) When the circumstances in (d)(1) or (2) exist, applicants and any dependents shall be placed on a waiting list in the order in which their completed applications were received by the program. When health plans are offered or funds become available, whichever is applicable, applicants and any dependents shall be enrolled in accordance with section 2698.203 based upon the order in which they appear on the program's waiting list.

(f) The program shall refund the initial subscriber contribution to all applicants who have been on the program's waiting list for more than 60 days from the date their completed applications were received. Such applicants shall, within 30 days of notification by the program that enrollment is possible, pay the initial subscriber contribution and notify the program of any additional dependents to be enrolled.

(g) The program shall complete the enrollment of an applicant on the waiting list within 15 days of receipt of payment of the initial subscriber contribution that has met the requirements of (f) of this section.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Sections 12711, 12725 and 12728, Insurance Code.

2698.203. Enrollment.

(a) Providing neither of the circumstances specified in section 2698.202(d) exists, applicants determined eligible for the program shall be enrolled in an available participating health plan of the applicant's choice in the applicant's county of residence.

(b) If an applicant applied to have dependents covered, dependents shall also be enrolled in the subscriber's participating health plan.

(c) The date on which the coverage shall begin, subject to the provisions of section 2698.303, shall be the first day of the month following enrollment.

(d) An applicant shall be notified in writing by the program of enrollment with a participating health plan, the beginning date of coverage by the participating health plan, and of any pre-existing condition exclusion period or post-enrollment waiting period. The notice shall caution the applicant about discontinuing any existing coverage until full coverage by the participating health plan has begun.

NOTE: Authority cited: Sections 10127.15, 12711, 12712 and 12712.5, Insurance Code. Reference: Sections 12711, 12725 and 12728, Insurance Code.

2698.204. Disenrollment

(a) Disenrollment shall occur when:

(1) The subscriber requests in writing to be disenrolled or that an enrolled dependent be disenrolled.

(2) The enrolled dependent requests in writing to be disenrolled.

(3) The dependent subscriber requests in writing to be disenrolled.

(4) The subscriber or dependent subscriber fails to make subscriber contributions in accordance with section 2698.403.

(5) The subscriber, enrolled dependent or dependent subscriber no longer meets the residency requirement.

(6) The subscriber, enrolled dependent or dependent subscriber has notified the program in writing of his/her eligibility for Part A and Part B of Medicare or the program becomes aware of his/her eligibility for Part A and Part B of Medicare, except subscribers, enrolled dependents or dependent subscribers on Medicare solely because of end-stage renal disease.

(7) The subscriber, enrolled dependent or dependent subscriber has been enrolled in the program for a period of 36 consecutive months from his/her respective start of coverage date.

(A) If the subscriber, enrolled dependent or dependent subscriber was initially subject to a post-enrollment waiting period, the length of that post-enrollment waiting period shall not be calculated as part of his/her 36 consecutive months of enrollment.

(B) If the subscriber, enrolled dependent or dependent subscriber was initially subject to a pre-existing condition exclusion period, the length of that pre-existing condition exclusion period shall be calculated as a part of his/her 36 consecutive months of enrollment.

(8) The subscriber, enrolled dependent or dependent subscriber has committed an act of fraud to circumvent the statutes or regulations of the program.

(9) Death of a subscriber, enrolled dependent or dependent subscriber.

(b) The subscriber or dependent subscriber shall be notified by the program in writing of the disenrollment of the subscriber and/or enrolled dependents or the dependent subscriber, the reason for the disenrollment, the effective date of the disenrollment, and shall be given an explanation of the appeals process.

(c) Disenrollment pursuant to (a)(1) and (a)(2) and (a)(3) of this section shall be effective on the last day of the month in which the written request was received.

(d) Disenrollment pursuant to (a)(4) of this section shall be retroactive to the last day of the month for which the required subscriber contribution was paid in full.

(e) Disenrollment pursuant to (a)(5) of this section shall be effective on the last day of the month in which the program determines that the subscriber, enrolled dependent or dependent subscriber no longer meets the residency requirement.

(f) Disenrollment pursuant to (a)(6) of this section shall be effective on the last day of the month in which the subscriber's or the dependent subscriber's written notification that the subscriber and/or the enrolled dependent or the dependent subscriber is now eligible for Medicare Part A and Part B was received or on the last day of the month in which the program becomes aware of the subscriber's, enrolled dependent's or dependent subscriber's eligibility for Medicare Part A and Part B.

(g) Disenrollment pursuant to (a)(7) of this section shall be effective on the last day of the subscriber's, enrolled dependent's or dependent subscriber's 36th consecutive month of enrollment.

(1) The subscriber, enrolled dependent or dependent subscriber shall be notified by the program in writing of their disenrollment from the program, pursuant to (a)(7) of this section, 90 days in advance of the end of his/her 36th consecutive month of enrollment. The notice shall contain his/her effective date of disenrollment and shall provide information regarding the availability of guaranteed coverage in the private insurance market pursuant to Health and Safety Code section 1373.62 and Insurance Code section 10127.15.

(2) The program shall mail a second notice to the subscriber, enrolled dependent or dependent subscriber no less than 45 days in advance of the end of his/her 36th consecutive month of enrollment. The notice shall contain his/her effective date of disenrollment and a Certificate of Program Completion.

(h) Disenrollment pursuant to (a)(8) of this section shall be effective on the last day of the month in which the program determines that the subscriber, enrolled dependent or dependent subscriber has committed an act of fraud to circumvent the statutes or regulations of the program.

(i) Disenrollment pursuant to (a)(9) of this section shall be effective on the last day of the month in which death occurred.

(j) If disenrolled for any reason, a subscriber and enrolled dependent, if any, or a dependent subscriber shall not be eligible for enrollment in the program for 12 months from the date of disenrollment.

(k) Subscribers, enrolled dependents or dependent subscribers disenrolled pursuant to (a)(7) of this section who are eligible for the Pilot Program and elect that coverage, shall not be eligible for enrollment in the program for a period of 12 months from the date of disenrollment from the Pilot Program standard benefit plan if the disenrollment from the Pilot Program standard benefit plan was a result of:

(1) A request to voluntarily disenroll; or

(2) Non-payment of premiums due for the Pilot Program standard benefit plan; or

(3) An act of fraud.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code; ASSEM. Bill No. 1401 (stats. 2002, ch. 794, Sec. 21). Reference: Sections 10127.15, 12711, 12733 and 12735, Insurance Code; and Section 1363.62, Health and Safety Code.

2698.205. Continuation of Benefits.

(a) If a subscriber is disenrolled pursuant to section 2698.204(a)(5) or 2698.204(a)(6), 2698.204(a)(7) or 2698.204(a)(9), an enrolled dependent shall be eligible for continued coverage in the program as a dependent subscriber for as long as he/she continues to meet the requirements of section 2698.200(c).

(b) If an enrolled dependent loses his or her dependent status due to divorce from the subscriber, the enrolled dependent shall be eligible for continued coverage in the program as a dependent subscriber for as long as he/she continues to meet the requirements of section 2698.200(c).

(c) An enrolled dependent that remains eligible pursuant to this section shall become a dependent subscriber and be subject to section 2698.204(a)(7), but shall not be required to demonstrate independent eligibility for the program.

NOTE: Authority cited: Sections 12711, 12712 and 12712.5, Insurance Code. Reference: Section 12730, Insurance Code.

2698.206. Dependent Coverage

(a) (1) Dependents may be enrolled:

(A) Within sixty (60) days of the date the individual became the subscriber's dependent; or

(B) Within sixty (60) days of the termination of a dependent's other health care coverage.

(2) A subscriber wishing to enroll additional dependents shall notify the program in writing of the full names, dates of birth, sex, social security numbers (not mandatory), and relationship of the dependents to be enrolled. Social Security numbers and other personal information are used for identification and administrative purposes.

(3) In order for the program to determine that a pre-existing condition exclusion or post-enrollment waiting period should be waived, or partially waived, the subscriber may also provide the documentation required by section 2698.201(e) for each dependent to be added. If no documentation is provided, the dependent shall be subject to the maximum pre-existing condition exclusion or post-enrollment waiting period described in section 2698.303. Dependents age 18 and under are not subject to pre-existing condition exclusion or post-enrollment waiting periods.

(4) (A) Coverage for newborns and adopted children eligible pursuant to (a)(1) of this section shall begin upon birth or the date on which the adoptive child's birth parents or other appropriate legal authority signs a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or a relinquishment form, granting the subscriber or the subscriber' spouse, the right to control health care for the adoptive child or, absent this written document, on the date there exists evidence of the right of the subscriber or the subscriber's spouse, to control the health care of the child placed for adoption.

(B) Coverage for all other dependents eligible pursuant to (a)(1) of this section shall begin within 3 months of receipt of the notification to the program from the subscriber, and shall begin on the first day of a month, subject to the provisions of section 2698.303.

(5) Subscribers shall be notified in writing by the program of the beginning date of coverage by the subscriber's health plan for enrolled dependents, and, if applicable, of any pre-existing condition exclusion period or post-enrollment waiting period. The notice shall caution the subscriber about

discontinuing any existing coverage for dependents until full coverage by the subscriber's health plan has begun.

(6) The subscriber contribution shall be adjusted as of a dependent's beginning date of coverage by the program; unless the dependent added was a newborn or an adopted child.

(7) The subscriber contribution for a newborn or an adopted child who is enrolled pursuant to (a)(1)(A) of this section shall be adjusted as of the first day of the month following the child's birth or first day of the month following the date on which the adoptive child's birth parents or other appropriate legal authority signs a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or a relinquishment form, granting the subscriber or the subscriber' spouse, the right to control health care for the adoptive child or, absent this written document, on the first day of the month following the date there exists evidence of the right of the subscriber or the subscriber's spouse, to control the health care of the child placed for adoption.

(b) (1) A subscriber wishing to disenroll dependents shall notify the program of the full names, dates of birth, sex, social security numbers, and relationship of the dependents to be disenrolled. Disenrollment of dependents shall be subject to sections 2698.204(a)(1), 2698.204(a)(2) and 2698.204(c).

(2) The subscriber contribution shall be adjusted, if applicable, as of the date of a dependent's disenrollment by the program.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Section 12729, Insurance Code.

2698.207. Transfer of Enrollment

(a) A subscriber and enrolled dependents, if any, or a dependent subscriber shall be transferred from one participating health plan to another if any of the following occurs:

(1) The subscriber or dependent subscriber so requests, in writing, during an open enrollment period established by the Board. The program shall inform each subscriber or dependent subscriber of each open enrollment period.

(2) The subscriber or dependent subscriber so requests, in writing, because the subscriber or dependent subscriber has moved and no longer resides in an area served by the participating health plan in which the subscriber or dependent subscriber is enrolled, and there is at least one participating

health plan serving the area in which the subscriber or dependent subscriber now resides that is accepting new enrollees.

(3) The subscriber or dependent subscriber or the participating health plan so requests, in writing, because of failure to establish a satisfactory subscriber-plan relationship and the executive director determines that the transfer is in the best interests of the program, and there is at least one participating health plan serving the area in which the subscriber or dependent subscriber resides that is accepting new enrollees.

(b) Subscribers, enrolled dependents and dependent subscribers who transfer enrollment pursuant to this section shall not be subject to pre-existing condition exclusions or post-enrollment waiting periods as specified in section 2698.303.

(c) Transfer of enrollment pursuant to (a)(1) shall take effect 30 days after the termination of an open enrollment period. Transfer of enrollment pursuant to (a)(2) or (a)(3) shall take effect within 35 days of approval of the request.

(d) Subscribers or dependent subscribers and participating health plans shall be notified in writing of any transfer of enrollment.

(e) If applicable, the subscriber contribution shall be adjusted as a result of a transfer of enrollment.

NOTE: Authority cited: Sections 12711, 12712 and 12712.5, Insurance Code. Reference: Section 12731, Insurance Code.

2698.208. Payment to Insurance Agents and Brokers

(a) If authorized by the board, the program shall pay an insurance agent as defined in section 31 of the Insurance Code or broker as defined in section 33 of the Insurance Code for assisting an individual in completing the application form, if the following conditions are met:

(1) The individual is enrolled as a result of the application;

(2) The agent or broker requests such payment in writing; and

(3) Such request accompanies the application and includes the name, license number, tax identification number or social security number, telephone number, and fax number (if available), signature, and address of the agent or broker.

(b) The amount of such payment shall be $50.00.

NOTE: Authority cited: Sections 12711, 12712 and 12712.5, Insurance Code.
Reference: Sections 12711 and 12711.5, Insurance Code.

Article 3. Minimum Scope of Benefits

2698.300. Deductible and Copayment

(a) Each participating health plan shall be permitted to require copayments and deductibles for benefits provided to a subscriber and enrolled dependents or dependent subscribers subject to the following limits:

(1) The copayment shall not exceed 25 percent of the cost of covered services. However, health plans not utilizing a deductible may be authorized to charge an office visit copayment of up to twenty-five dollars ($25).

(2) The deductible shall not exceed $500 annually for a household, which consists of a subscriber and any enrolled dependents or of a dependent subscriber.

(3) The sum of the copayment and deductible shall not exceed $2,500 annually for a subscriber or dependent subscriber or $4,000 annually for a subscriber and enrolled dependents.

(b) When a subscriber's or dependent subscriber's selected participating health plan is a plan that has contracts with certain listed providers from whom care is to be received for non-emergency conditions, and there are additional subscriber payments to providers other than those listed, such additional subscriber payments shall not be subject to the limits of this section.

NOTE: Authority cited: Sections 12711 and 12712 Insurance Code. Reference: Section 12718, Insurance Code

2698.301. Minimum Scope of Benefits

(a) The basic minimum scope of benefits offered by participating health plans to subscribers, dependent subscribers and enrolled dependents must comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975 including amendments as well as its applicable regulations, and shall include all of the benefits and services listed in this section. Except as required by the applicable statute and regulations, no other benefits shall be permitted to be offered by a participating health plan unless specifically provided for in the program contract with the participating health plan. The basic minimum scope of benefits shall be as follows:

(1) Hospital inpatient care in a hospital licensed pursuant to subdivision (a) of section 1250 of the Health and Safety Code, including all of the following benefits and services:

(A) Semi-private room, including meals and general nursing services; and private room and special diets when prescribed as medically necessary.

(B) Hospital services, including use of operating room and related facilities, intensive care unit and services, labor and delivery room, and anesthesia.

(C) Drugs, medications, and parenteral solutions administered while an inpatient.

(D) Dressing, casts, equipment, oxygen services, and radiation therapy.

(E) Respiratory and physical therapy.

(F) Diagnostic laboratory and x-ray services.

(G) Special duty nursing as medically necessary.

(H) Administration of blood and blood products.

(I) Other diagnostic, therapeutic or rehabilitative services (including occupational, physical and speech therapy) as appropriate.

(J) Medically necessary inpatient alcohol and substance abuse.

(K) General anesthesia and associated facility charges in connection with dental procedures rendered in a hospital, when the clinical status or underlying medical condition of a subscriber, enrolled dependent or dependent subscriber requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital. This benefit is only available to subscribers, enrolled dependents or dependent subscribers under seven years of age; the developmentally disabled, regardless of age; and subscribers, enrolled dependents or dependent subscribers whose health is compromised and for whom general anesthesia is medically necessary, regardless of age.

Nothing in this section shall require a participating health plan to cover any charges for the dental procedure itself, including, but not limited to, the professional fee of the dentist.

(2) Medical and surgical services, provided on an outpatient basis whenever medically appropriate, including all of the following:

(A) Physician services including consultations, referrals, office and hospital visits and surgical services performed by a physician and surgeon.

(B) Diagnostic laboratory services, diagnostic and therapeutic radiological services and other diagnostic services that shall include but not be limited to nuclear medicine, ultrasound, electrocardiography and electroencephalography.

(C) Dressings, casts and use of castroom, anesthesia, and oxygen services when medically necessary.

(D) Blood, blood derivatives and their administration.

(E) Radiation therapy and chemotherapy, of proven benefit.

(F) Comprehensive preventive care of children, 16 years of age or younger which is consistent with the Recommendations for Preventive Pediatric Health Care as adopted by the American Academy of Pediatrics in September of 1987, and the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians. Comprehensive preventive care services shall in include periodic health evaluations, immunizations and laboratory services in connection with periodic health evaluations.

(G) General anesthesia and associated facility charges in connection with dental procedures rendered in a surgery center setting, when the clinical status or underlying medical condition of a subscriber, enrolled dependent or dependent subscriber requires dental procedures that ordinarily would not require general anesthesia to be rendered in a surgery center setting. This benefit is only available to subscribers, enrolled dependents or dependent subscribers under seven years of age; the developmentally disabled, regardless of age; and subscribers, enrolled dependents or dependent subscribers whose health is compromised and for whom general anesthesia is medically necessary, regardless of age.

Nothing in this section shall require a participating health plan to cover any charges for the dental procedure itself, including, but not limited to, the professional fee of the dentist.

(H) Nothing in this section shall preclude the direct reimbursement of physician assistants, nurse practitioners or other advanced practice

nurses who provide covered services within their scope of licensure.

(3) Family planning services including a variety of prescriptive contraceptive methods approved by the federal Food and Drug Administration, and reproductive sterilization.

(4) Comprehensive maternity and perinatal care, including the services of a physician and surgeon, certified nurse midwife or nurse practitioner, and all necessary hospital services, including services related to complications of pregnancy, are covered services. Nothing in this section shall preclude the direct reimbursement of nurse practitioners or other advanced practice nurses in providing covered services.

(5) Emergency care including out-of-area coverage. Emergency ambulance transportation including transportation provided through the "911" emergency response system.

(6) Reconstructive Surgery: Surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following;

(A) improve function.

(B) create a normal appearance to the extent possible.

Includes reconstructive surgery to restore and achieve symmetry incident to mastectomy.

(7) Prescription drugs, limited to drugs approved by the federal Food and Drug Administration, generic equivalents approved as substitutable by the federal Food and Drug Administration, or drugs approved by the federal Food and Drug Administration as Treatment Investigational New Drugs. Also includes insulin, glucagon, syringes and needles and pen delivery systems for the administration of insulin, blood glucose testing strips, ketone urine testing strips, lancets and lancet puncture devices in medically appropriate quantities for the monitoring and treatment of insulin dependent, non-insulin dependent and gestational diabetes.

(8) Mental Health benefits are covered as follows:

(A) For severe mental illnesses, and serious emotional disturbances of children, inpatient services, outpatient services, partial hospitalization services and prescription medications. Severe mental illnesses include schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder,

obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa.

(B) Except as specified in Subsection (A) above, mental health benefits are limited to the following:

1. Inpatient care for a period of 10 days in each calendar year.

2. 15 outpatient visits in each calendar year.

(9) Medical rehabilitation and the services of occupational therapists, physical therapists, and speech therapists as appropriate on an outpatient basis.

(10) Durable medical equipment, including prosthetics to restore and achieve symmetry incident to a mastectomy and to restore a method of speaking incident to a laryngectomy. Covered services also include blood glucose monitors and blood glucose monitors for the visually impaired for insulin dependent, non-insulin dependent and gestational diabetes; insulin pumps and all related necessary supplies; visual aids to assist the visually impaired with proper dosing of insulin and podiatric devices to prevent or treat diabetes complications.

(11) Home Health Services: Health services provided at the home by health care personnel. Includes visits by Registered Nurses, Licensed Vocational Nurses, and home health aides; physical, occupational and speech therapy; and respiratory therapy when prescribed by a licensed practitioner acting within the scope of his or her licensure.

(12) The following human organ transplants: corneal, human heart, heart-lung, liver, bone-marrow and kidney transplantation. Transplants other than corneal shall be subject to the following restrictions:

(A) Pre-operative evaluation, surgery, and follow-up care shall be provided at centers that have been designated by the participating health plan as having documented skills, resources, commitment and record of favorable outcomes to qualify the centers to provide such care.

(B) Patients shall be selected by the patient-selection committee of the designated centers and subject to prior authorization.

(C) Only anti-rejection drugs, biological products, and other procedures that have been established as safe and effective, and no longer investigational, are covered.

(13) Hospice services pursuant to Health and Safety Code section 1368.2.

(14) This part shall not be construed to prohibit a plan's ability to impose cost-control mechanisms. Such mechanisms may include but are not limited to requiring prior authorization for benefits or providing benefits in alternative settings or using alternative methods.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Sections 12711 and 12712, Insurance Code.

2698.302. Excluded Benefits

(a) Plans offered under this program shall exclude the following benefits unless specifically provided for in the program contract with the participating health plan:

(1) Services that are not medically necessary. "Medically necessary" as applied to the diagnosis or treatment of illness is an article or service that is not investigational and is necessary because:

(A) It is appropriate and is provided in accordance with accepted medical standards in the state of California, and could not be omitted without adversely affecting the patient's condition or the quality of medical care rendered; and

(B) As to inpatient care, it could not have been provided in a physician's office, in the outpatient department of a hospital, or in a lesser facility without adversely affecting the patient's condition or the quality of medical care rendered; and

(C) If the proposed article or service is not commonly used, its application or proposed application has been preceded by a thorough review and application of conventional therapies; and

(D) The service or article has been demonstrated to be of significantly greater therapeutic value than other, less expensive, services or articles.

(2) Any services which are received prior to the enrollee's effective date of coverage.

(3) Custodial, domiciliary care, or rest cures for which facilities of a general acute care hospital are not medically required. Custodial care is care that does not require the regular services of trained medical or health professionals and that is designed primarily to assist in activities of daily living. Custodial care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of

special diets, and supervision of medications which are ordinarily self-administered.

(4) Personal or comfort items, or a private room in a hospital unless medically necessary.

(5) Emergency facility services for nonemergency conditions.

(6) Those medical, surgical (including implants), or other health care procedures, services, drugs, or devices which are either:

(A) Services, products, drugs or devices which are experimental or investigational or which are not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question.

(B) Outmoded or not efficacious.

(7) Transportation except as specified in section 2698.301(a)(5).

(8) Implants, except cardiac pacemakers, intraocular lenses, screws, nuts, bolts, bands, nails, plates, and pins used for the fixation of fractures or osteotomies and artificial knees and hips; and except as specified in section 2698.301(a)(6).

(9) Sex change operations, investigation of or treatment for infertility, reversal of sterilization, and conception by artificial means.

(10) Eyeglasses, contact lenses (except the first intraocular lens following cataract surgery), routine eye examinations, including eye refractions, except when provided as part of a routine examination under "preventive care for minors," hearing aids, orthopedic shoes, orthodontic appliances, and routine foot care are excluded.

(11) Long-term care benefits including home care, skilled nursing care, and respite care, are excluded except as a participating health plan shall determine they are less costly alternatives to the basic minimum benefits.

(12) Dental services and services for temporomandibular joint problems are excluded, except for repair necessitated by accidental injury to sound natural teeth or jaw, provided that the repair commences within 90 days of the accidental injury or as soon thereafter as is medically feasible.

This language shall not be construed to exclude surgical procedures for condition directly affecting the upper or lower jawbone, or associated joints.

(13) Treatment of chemical dependency except as specified in section 2698.301 (a)(1)(J).

(14) Cosmetic surgery, except as specifically provided in section 2698.301(a)(6).

(b) Benefits which exceed $75,000 in a calendar year under the program for a subscriber, or a subscriber's enrolled dependent or a dependent subscriber shall be excluded.

(c) Benefits which exceed $750,000 in a lifetime under the program for a subscriber, a subscriber's enrolled dependent or dependent subscriber shall be excluded. Benefits received prior to January 1, 1999 shall be counted towards the $750,000 lifetime maximum.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Sections 12711 and 12712, Insurance Code.

2698.303. Pre-Existing Conditions Exclusion and Post-enrollment Waiting Period.

(a) Unless a waiver is granted pursuant to subsection (c), subscribers and enrolled dependents who enroll in a health maintenance organization participating health plan shall be subject to a post-enrollment waiting period. The post-enrollment waiting period shall apply to all subscribers and enrolled dependents. Subscribers shall not be required to pay subscriber contributions during the waiting period. The post-enrollment waiting period shall be 3 months unless reduced pursuant to subsection (d).

(b) Unless a waiver is granted pursuant to subsection (c), subscribers and enrolled dependents who enroll in a fee-for-service participating health plan shall be subject to a pre-existing condition exclusion period. During the pre-existing condition exclusion period no benefits or services related to a pre-existing condition shall be covered. Subscribers shall be required to pay subscriber contributions during the pre-existing condition exclusion period. The pre-existing condition exclusion period shall be 3 months unless reduced pursuant to subsection (d).

(c) Waivers or partial waivers to the post-enrollment waiting period or pre-existing condition exclusion period shall be granted for each individual subscriber or enrolled dependent providing any of the following criteria are met:

(1) The subscriber and/or enrolled dependent applies for the program within 180 days of the termination of prior creditable coverage, and such coverage was terminated due to:

(A) a loss of employment,

(B) the employer stopped offering or sponsoring health coverage, or

(C) the employer stopped making contributions towards health coverage.

(2) If the subscriber or enrolled dependent applies for the program within 63 days of the termination of prior creditable coverage and such coverage was terminated due to reasons other than:

(A) the criteria in (c)(1)(A), (B), or (C) of this section;

(B) non-payment of premiums; or

(C) fraud.

(3) The subscriber or dependent(s) who had previously received coverage under a similar program in another state within the last 12 months, shall be granted a full waiver of 3 months.

(4) A dependent age 18 and under who enrolled pursuant to section 2698.206 shall be granted a full waiver of 3 months.

(5) The subscriber who was on the program waiting list in accordance with Section 2698.202 for 180 days or longer shall be granted a full waiver of 3 months. A full waiver of 3 months shall also be granted for any dependents enrolled at the same time as the subscriber.

(d) Waivers or partial waivers to the post-enrollment waiting period or pre-existing condition exclusion period for individuals meeting the requirements of (c)(1) or (c)(2) of this section shall be calculated as follows:

(1) If the prior creditable coverage was for 3 consecutive months or more, a full waiver of 3 consecutive months shall be granted.

(2) If the prior creditable coverage was for 2 consecutive months, a partial waiver of 2 consecutive months shall be granted.

(3) If the prior creditable coverage was for 1 month, a partial waiver of 1 month shall be granted.

(4) If the prior creditable coverage was for less than 1 month, no waiver shall be granted.

(e) The program shall fully explain to applicants the type of health care coverage offered by each participating health plan, including the applicable waiting/exclusion periods specified in this section.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Section 12726, Insurance Code.

Article 4. Risk Categories and Subscriber Contributions

2698.400. Risk Categories.

(a) The risk categories on which the program and subscriber contributions are to be determined shall be the following;

(1) Six (6) geographic regions:

(A) Area 1 shall include the counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yuba, and Yolo.

(B) Area 2 shall include the counties of Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus.

(C) Area 3 shall include the counties of Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara.

(D) Area 4 shall include the counties of Orange, Santa Barbara, and Ventura.

(E) Area 5 shall include the county of Los Angeles.

(F) Area 6 shall include the counties of Riverside, San Bernardino, and San Diego.

(2) twelve (12) age groups:

(A) Under 15 years of age;

(B) 15-29 years of age;

(C) 30-34 years of age;

(D) 35-39 years of age;

(E) 40-44 years of age;

(F) 45-49 years of age;

(G) 50-54 years of age;

(H) 55-59 years of age;

(I) 60-64 years of age;

(J) 65-69 years of age;

(K) 70-74 years of age; and

(L) 75 years of age and older.

(b) No other risk categories shall be allowed for the purpose of this program.

Note: Authority cited: Sections 12711, 12712 and 12712.5, Insurance Code. Reference: Section 12736, Insurance Code

2698.401. Determination of Subscriber Contribution

(a) Each participating health plan shall provide an annual estimate of the standard average individual rate for the minimum benefits provided for in the contract with the participating health plan for each risk category specified in Section 2698.400. Without applying risk categories to dependents or dependent subscribers, each participating health plan shall also provide an estimate of the standard average rate for covering a subscriber in each risk category and the subscriber's dependents as follows:

(1) A subscriber and one dependent; and

(2) A subscriber and two or more dependents.

(b) For those participating health plans which have been offered through the program for two or more years, the Board shall calculate a loss ratio for each participating health plan for the prior calendar year. The loss ratio shall be calculated using 125 percent of the estimated rates provided by the participating plan as the denominator, and the sum of all medical costs for subscribers, dependent subscribers and dependents enrolled in the plan and all administration fees and risk payments to the plan as the numerator.

(c) For those participating health plans which have been offered through the program for two or more years, the Board shall calculate a percentage average subsidy amount per subscriber dollar contributed for each participating health plan for the prior calendar year by subtracting 100 percent from the program loss ratio percentage.

(d) The Board shall calculate the program loss ratio for the prior calendar year in the following manner:

(1) Participating health plans with an average monthly number of enrollees of fewer than 1,000 in the prior calendar year shall be excluded from the calculation.

(2) If a participating health plan's loss ratio is less than 100 percent it shall be deemed to be 100 percent for purposes of the calculation.

(3) The weighted average of the participating health plans' loss ratios is the program loss ratio.

(e) The Board shall calculate the program average subsidy for the prior calendar year by subtracting 100 percent from the program loss ratio percentage.

(f) For each participating health plan with an average subsidy percentage amount higher than the program average subsidy percentage, that difference shall be called the excess subsidy.

(g) The Board shall determine the subscriber contribution for each participating health plan that did not have an excess subsidy in the prior calendar year by multiplying the estimated rates provided by the participating health plan by 125 percent.

(h) The Board shall determine the base subscriber contribution for each participating health plan that did have an excess subsidy in the prior calendar year by multiplying the estimated rates provided by the participating health plan by an additional 25 percent and then adding the excess subsidy amount. However, the actual subscriber contribution shall be subject to the following limitations:

(1) No subscriber contribution will be more than 10 percent above 125 percent of the estimated rates provided by the participating plan. (See Title 10, section 2698.100(dd).

(2) If all participating health plans available in a county have an excess subsidy amount, the subscriber contribution for the plan with the lowest excess subsidy amount will not include the excess subsidy amount.

(i) Subscriber contribution for participating health plans joining the program after January 1, 1997, shall be established at 125 percent of the estimated rates provided by the participating plan for the first two benefit years the plan participates in the program. (See Title 10, section 2698.100(dd).

(j) Subscriber contributions shall be adjusted annually in accordance with this section.

(k) Subscribers and dependent subscribers shall be informed by the program of the annually adjusted subscriber contribution at least one month prior to the effective date of the rate charge.

NOTE: Authority cited: Sections 12711 and12712 Insurance Code. Reference: Section 12713, 12736, 12737 and 12738, Insurance Code.

2698.403. Subscriber Contribution Payments

Subscriber contribution payment procedures shall be as follows:

(a) Each month the program shall determine the amount of the subscriber contribution in accordance with sections 2698.400 and 2698.401 and notify the subscriber or dependent subscriber of the subscriber contribution amount due to the program and the due date. The program shall send the notice at least 30 days in advance of the due date.

(b) A subscriber or dependent subscriber shall submit the subscriber contribution to the program each month so that it is received no later than the first of each month for that month of coverage.

(c) The obligation to submit the subscriber contribution amount required by subsection (b) above is not contingent upon receipt of the notice specified in subsection (a). If the subscriber or dependent subscriber does not receive the notice specified in subsection (a) above, the subscriber or dependent subscriber shall make a good faith effort to determine the amount of the subscriber contribution and shall submit a payment of that amount by the due date.

(d) The subscriber contribution amount shall be calculated based on the subscriber's or the dependent subscriber's age as defined in section 2698.400.

(e) Adjustments to the subscriber contribution amount due to a change in the subscriber's or the dependent subscriber's age group as defined in section 2698.400 shall occur on the first day of the month following the subscriber's or the dependent subscriber's birth date.

(f) The subscriber contribution amount for a dependent subscriber shall be adjusted on the first of the month following the dependent's divorce, or the subscriber's disenrollment from the program. The adjusted subscriber contribution amount shall be calculated based on the dependent subscriber's age as defined in section 2698.400.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Section 12737, Insurance Code.

2698.405. Overdue Payments

(a) A subscriber or dependent subscriber whose subscriber contribution is not paid in full for any reason by the due date shall be considered to be overdue.

(b) The program shall notify the subscriber or dependent subscriber of the overdue subscriber contribution payment amount and the potential for disenrollment from the program on the 10th day following the due date when the current month's premium is paid before the next month's due date. An exception to this is specified in subsection (c).

(c) When the previous month's subscriber contribution is received on the due date for the current month, a final notice will be generated on the 15th day following the due date for the current month.

(d) Subscriber contributions more than 31 days overdue shall result in the subscriber and any enrolled dependents or the dependent subscriber being disenrolled pursuant to section 2698.204.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Section 12735, Insurance Code

2698.407. Reinstatement

(a) A subscriber and enrolled dependents, if any, or a dependent subscriber who is disenrolled for nonpayment of the subscriber contribution may be reinstated once during a rolling twelve (12) month period if the subscriber or dependent subscriber requests reinstatement within sixty (60) days of the date of the disenrollment action and brings all delinquent payments up to date.

(b) A subscriber and enrolled dependents, if any, or a dependent subscriber who is disenrolled more than once during a rolling twelve (12) month period for nonpayment of the subscriber contribution may only be reinstated through an appeal to the board as set forth in section 2698.500 except as specified in subsection (c).

(c) A subscriber and enrolled dependents, if any, or a dependent subscriber who has been disenrolled due to the submission of two checks which were returned for insufficient funds during a rolling twelve (12) month period will not be reinstated.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Section 12735, Insurance Code

Article 5. Appeals

2698.500. Appeals to the Board

(a) Any subscriber, enrolled dependent or dependent subscriber who is dissatisfied with any action or failure to act which has occurred in connection with a participating health plan's coverage may file an appeal with the Board.

(b) In addition, the following decisions may be appealed to the Executive Director only:

(1) A program determination as to eligibility of any applicant or the applicant's dependents.

(2) A program determination to disenroll a subscriber, enrolled dependent or dependent subscriber from the program.

(3) A program determination to deny a subscriber or dependent subscriber request or to grant a participating health plan request to transfer the subscriber to a different participating health plan.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Sections 12711 and 12732, Insurance Code.

2698.501. Dispute Resolution

Notwithstanding other sections in this Article, when a subscriber, enrolled dependent or dependent subscriber is dissatisfied with any action, or inaction, of the program's participating health plan in which he/she is enrolled, the subscriber, enrolled dependent or dependent subscriber shall first attempt to resolve the dispute with the participating health plan according to its established policies and procedures.

NOTE: Authority cited: Sections 12711, 12712 and 12712.5, Insurance Code.
Reference: Sections 12711 and 12732, Insurance Code.

2698.502. Filing an Appeal

(a) An appeal shall be filed in writing with the Executive Director within sixty (60) days of the action or failure to act or receipt of notice of the decision being appealed.

(b) An appeal shall include all of the following:

(1) A copy of any decision being appealed; or a written statement of the action or failure to act being appealed;

(2) A statement specifically describing the issues which are disputed by the appellant;

(3) A statement of the resolution requested by the appellant; and

(4) Any other relevant information the appellant wants to include.

(c) Any appeal that does not include all necessary information shall be returned to the appellant without review. The appellant may re-submit the appeal within the time limits of subsection (a) or within twenty (20) days of the receipt of the returned appeal, whichever is later.

NOTE: Authority cited: Sections 12711 and 12712 Insurance Code. Reference: Sections 12711 and 12732, Insurance Code.

2698.503. Administrative Review

(a) Any appeal filed pursuant to this Article will be given an administrative review.

(b) Administrative reviews of appeals shall be conducted by the Executive Director.

(c) In conducting an administrative review of an appeal, the Executive Director may contact the appellant and/or the participating health plan for further information.

(d) The Executive Director's decision shall be in writing.

(e) If an appeal was filed pursuant to section 2698.500(a), the appellant retains the right to request an administrative hearing if the appellant is not satisfied with the decision of the Executive Director. Such a request shall be filed within thirty (30) days of receipt of the Executive Director's decision. It shall include a clear and concise statement of what action is being appealed, and the reason(s) the Executive Director’s decision is not correct.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Sections 12711 and 12732, Insurance Code.

2698.504. Hearings

Upon receipt of an appeal which requests an administrative hearing, the Board shall determine the appropriate forum as follows:

(a) An appeal filed pursuant to subsection (a) of section 2698.500 shall be reviewed by the Board to determine whether it is practicable to have the hearing conducted by an Administrative Law Judge employed by the Office of Administrative Hearings pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. The Board will

determine practicability by considering such issues as timing, location and costs to the parties. If it is determined to be practicable, such a hearing shall be scheduled. If it is determined not to be practicable, the appeal shall be heard in accordance with subsection (b) of this Section.

(b) An appeal filed pursuant to subsection (a) of section 2698.500 but which it has been determined by the Board should be heard in accordance with this subsection, shall be heard according to the appeal procedures, including pre- and post-hearing procedures, set forth in Chapter 2.5 (commencing with section 251) of Division 2 of Title 1 of the California Code of Regulations. Chapter 2.5, as adopted on June 4, 1984, is hereby incorporated by reference, subject to the following modifications:

(1) Reference to the Health and Welfare Agency or the component department shall be deemed reference to the Managed Risk Medical Insurance Board.

(2) Reference to the private non-private human service organization shall be deemed reference to the petitioner.

(3) Reference to the grievance procedure established in accordance with Health and Safety Code section 38036 shall be deemed reference to the administrative review process set forth in section 2698.503.

(4) Reference to Health and Safety Code sections providing the bases, grounds, authorization or procedures for appeals shall be deemed reference to the bases and authorization for appeal found in section 2698.500, and the appeal procedures found in this section.

(5) The 30-day time period specified in section 251(b) shall be extended to 60 days, and the 10-day time period in section 252(a) shall be extended to 30 days.

(6) If the proposed decision submitted to the Board is not adopted as the decision, the Board may itself decide the case on the record, or may refer the case to the same hearing officer to take additional evidence. If the case is referred back to the hearing officer, the hearing officer shall prepare a new proposed decision based on the additional evidence and the record of the prior hearing.

(7) The decision of the Board shall be issued within 90 days following the initial hearing or, if the case is referred back to the hearing officer, within 90 days of the second hearing.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Sections 12711 and 12732, Insurance Code.

Article 6. Pilot Program Payments

2698.600. Semiannual Interim Payment and Reporting Procedures for Pilot Program Health Plans

(a) The semiannual interim payment process for Pilot Program payment shall occur starting at the end of the first reporting period, September 1, 2003 through December 31, 2003, and on June 30 and December 31 of each year thereafter, as long as there are Program Graduates or Program Graduate dependents enrolled. In order to qualify for a semiannual interim payment a Pilot Program health plan shall submit a semiannual interim enrollment report no later than 90 days after the semiannual reporting period as established above in this section. If a Pilot Program health plan does not submit a semiannual interim enrollment report by the end of the 90 day period, the plan will not receive an interim payment for that period.

(b) The semiannual interim enrollment report shall be submitted for each program graduate enrolled in the Pilot Program standard benefit plan during the semiannual interim period, and consist of:

(1) A signed certification that all program graduates for whom the Pilot Program health plan has made claim are enrolled in a Pilot Program standard benefit plan.

(2) The following information, to be submitted electronically, in a format specified by the Board, which consists of the following elements for each Program Graduate enrolled in the Pilot Program standard benefit plan during the semiannual interim period:

(A) The Program Graduate’s unique identification number,

(B) The Pilot Program health plan’s own identification number for the Program Graduate,

(C) The Program Graduate’s full name,

(D) The Program Graduate’s home address including house or unit number, street, city, county, state, and zip code,

(E) The name of each Program Graduate dependent who is covered under the Pilot Program at the same time as the program graduate,

(F) The date of birth of each Program Graduate and Program Graduate dependent,

(G) The Program Graduate's and any Program Graduate dependent's date of disenrollment from the Program, as indicated on the Certificate of Program Completion,

(H) The Program Graduate's and any Program Graduate dependent's date of enrollment in the Pilot Program health plan,

(I) The Program Graduate's and any Program Graduate dependent's date of enrollment in the Pilot Program health plan, when transferred from one Pilot Program health plan to another.

(J) The Program Graduate's and any Program Graduate dependent's date of disenrollment in the Pilot Program health plan, if disenrollment has occurred during the interim semiannual reporting period.

(3) The semiannual interim enrollment report shall include an estimate, adjusted for incurred but not reported (IBNR) costs, of the amount expended for program graduates and program graduate dependents, and the total amount of premium payments received to the Pilot Program health plan during the reporting period.

(c) The Board will issue an interim payment no later then 60 days after receipt of a valid semiannual interim payment report, consisting of all the elements as stated above in subsection (b). The payment will be determined using the following formula for each individual:

the most recent average premium as established by the Board during its semiannual determination of estimated enrollment times one half (the absolute value of the prior calendar year loss ratio minus 110 percent)

(d) The semiannual interim payment reporting process shall be subject to review and/or audit by the Board or its authorized representative in order to verify Program Graduates, and Program Graduate dependents, enrollment through a Pilot Program health plan in the Pilot Program standard benefit plan, for a period of four years after an interim payment has been made.

NOTE: Authority cited: Sections 1373.62, Health and Safety Code; 10127.15, 12711 and 12712, Insurance Code. Reference: Sections 1373.62 and 1373.622, Health and Safety Code; and Sections 10127.15, 12711 and 12712, Insurance Code.

2698.602. Annual Reconciliation Reporting and Payment Process for Pilot Program Health Plans

(a) The time period for annual reconciliation, reports and payment shall be as follows:

(1) The annual reconciliation reporting and payment process shall start one year after the end of each reporting period established in Health and Safety Code Section 1373.62(g)(1) and Insurance Code 10127.15(g)(1). These periods are as follows:

September 1, 2003, to December 31, 2003, inclusive,
January 1, 2004, to December 31, 2004, inclusive,
January 1, 2005, to December 31, 2005, inclusive,
January 1, 2006, to December 31, 2006, inclusive,
January 1, 2007, to August 30, 2007, inclusive.

(2) However, for the purpose of reconciliation and payment, the January 1, 2007 to August 30, 2007 reporting period shall be extended through December 31, 2007, and shall include Program Graduates and Program Graduate dependents that remain enrolled in a Pilot Program health plan's standard benefit plan on September 1, 2007 (the day the Pilot Program becomes inoperative). Pilot Program health plans with such program graduates or program graduate dependents may continue to report, and be eligible for reconciliation and payment, one year after the close of each calendar year until the plan no longer has any remaining program graduates or program graduate dependents.

(b) In order to qualify for annual reconciliations, a Pilot Program health plan shall submit an annual report by December 31 of each year, starting in December 2004. Pilot Program health plans who submit these reports by the established due dates will be given priority for reconciliation and any resulting payments. Pilot Program health plans who submit reports after the established due dates will be reconciled, and any resulting payments made from available funds, in order of the day of receipt of the report.

(c) The annual report to be submitted by Pilot Program health plans shall consist of three parts:

(1) For a Program Graduate and a Program Graduate dependent enrolled in a Pilot Program standard benefit plan, an enrollment and program report to be submitted electronically, in a format to be specified by the Board, for the reporting periods established above in subsection (a)(1) and (2):

(A) The Program Graduate's unique identification number,

(B) The Pilot Program health plan's own identification number for the Program Graduate,

(C) The Program Graduate's full name,

(D) The Program Graduate's home address including house or unit number, street, city, county, state and zip code,

(E) The name of each Program Graduate dependent who is covered under the Pilot Program at the same time as the Program Graduate,

(F) The date of birth of each Program Graduate and Program Graduate dependent,

(G) The Program Graduate's and any Program Graduate dependent's date of disenrollment from the Program, as indicated on the Certificate of Program Completion,

(H) The Program Graduate's and any Program Graduate dependent's date of enrollment in the Pilot Program health plan,

(I) The Program Graduate's and any Program Graduate dependent's date of enrollment in the Pilot Program health plan, when transferred from one Pilot Program health plan to another.

(J) The Program Graduate's and any Program Graduate dependent's date of disenrollment in the Pilot Program health plan, if disenrollment has occurred during the annual reporting period, and if disenrollment was the result of any of the following:

1. Program Graduate's request;
2. eligibility for Medicare Part A and Part B;
3. eligibility for other health insurance;
4. non-payment of premiums;
5. fraud;
6. death; or
7. other.

(K) Dollar amount of all premiums paid by, or on behalf of each Program Graduate, and Program Graduate dependent for coverage in the Pilot Program standard benefit plan during the reporting period.

(2) A claims report, to be provided electronically for each program graduate and program graduate dependent enrolled with the Pilot Program health plan for service provided and expense payments made during the annual reporting period. The reporting expense payments shall be limited to expense payments made to providers of services and shall not include the Pilot Program health plan administrative expenses, and shall not include incurred but not reported costs. The report, entitled "Major Risk Medical Insurance Pilot Program Health Plan and Claims Reporting File Layout

and Field Description, dated September, 2003 is hereby incorporated by reference.

(3) A signed certification that all program graduates for whom the Pilot Program health plan has made claim are enrolled in a Pilot Program standard benefit plan.

(4) An incomplete report shall be returned with an explanation to the Pilot Program health plan of the reasons for incompleteness.

(d) The Board will review and reconcile each annual complete report within 120 days of receipt to the Pilot Program health plan of the findings based on the following formula:

one half (aggregate claims minus aggregate premiums) plus aggregate standard monthly administrative fee minus semiannual interim payments paid for that reporting period equals Final Payment.

In order to determine an aggregate monthly administrative fee for individuals in the Pilot Program, the Board will use a weighted average, weighted by plan population and adjusted by a factor of the number of dependents in the Program, of the current administrative fees for plans participating in the Program.

(1) The Board may make adjustments in determining the final payment to any Pilot Program health plan as follows:

(A) to delete any payments for persons who cannot be determined to be a Program Graduate or Program Graduate dependent during the reporting period,

(B) to delete expenses for services beyond the date of disenrollment during a reporting period for a Program Graduate or Program Graduate dependent,

(C) to delete expenses for services for the Program Graduate or Program Graduate dependent beyond the date of eligibility for Medicare Part A and Medicare Part B, and who are not in Medicare solely because of end stage renal disease,

(D) to delete expenses that occurred for services outside of the reporting period, and

(E) to delete all expenses beyond the $200,000 annual and $750,000 lifetime benefit limits for each individual in a Pilot Program standard benefit plan.

(2) If the current reconciliation indicates that further payment is owed to the Pilot Program health plan, the payment shall be made 30 days after notification of the reconciliation results. If the annual reconciliation indicates that an overpayment has been made through the semiannual interim payment process, the Pilot Program health plan shall pay the overpayment to the Board within 35 days after the notification of reconciliation.

(e) The annual reconciliation, reporting and payment process shall be subject to review and/or audit by the Board or its authorized representatives, for a period of four years after a reconciliation payment by either the Board or a Pilot Program health plan has been made.

NOTE: Authority cited: Sections 1373.62, Health and Safety Code; and Sections 10127.15, 12711 and 12712, Insurance Code. Reference: Sections 1373.62 and 1373.622, Health and Safety Code; and Sections 10127.15, 12711 and 12712, Insurance Code.

2698.604. Excess State Liability in the Pilot Program.

(a) The Board shall determine at least semiannually at a public meeting of the Board, the viability of the Major Risk Medical Insurance Fund, or other funding sources made available to the Board to make interim semiannual or final annual payments to Pilot Program health plans.

(b) If the Board determines that funds for the Pilot Program or for payments beyond the term of the Pilot Program are in a state of excess liability, the Board shall notify the Department of Managed Health Care, the Department of Insurance, and all Pilot Program health plans known to the Board, of the state of excess liability, within 30 days of the determination. The notification shall include a determination of the allowable premium rates change that may be charged to program graduates, to the amount the Board would charge without a state subsidy for the applicable standard benefit plan within the Major Risk Medical Insurance Program. Pilot Program health plans shall be allowed to charge these rates, consistent with the policies and procedures for rate increase notifications of the state department (either Department of Managed Health Care or Department of Insurance) which regulates the Pilot Program health plan.

NOTE: Authority cited: Sections 1373.62, Health and Safety Code; and Sections 10127.15, 12711 and 12712, Insurance Code. Reference: Sections 1373.62 and 1373.622, Health and Safety Code; and Sections 10127.15, 10127.16, 12711 and 12712, Insurance Code.